Reducing Health Disparities Through Cultural Competence

Diana L. Denboba, Judith L. Bragdon, Leonard G.Epstein, Karen Garthright, and Thurma McCann Goldman

Abstract

Activities relating to "cultural diversity" and "cultural competence" have gained a greater audience with the increase in culturally diverse populations in the United States. In the area of health care, issues range from managing and preparing a more diverse workforce to eliminate disparities in health outcomes to ensuring access and utilization of services by culturally diverse communities.

Cultural competence is inextricably [illegible]d to quality of care and is a cross-cutting issue affecting all service delivery systems and providers, including health educators. Health educators need to have an awareness of their own cultural values and beliefs with recognition for how they influence attitudes and behaviors (Randall-David, 1989). In addition, agencies and organizations should assess their cross-cultural strengths and weakness in terms of policies, procedures, practice, and structure. Respect for cultural values, traditions, and customs affects the willingness and ability of both individuals and organizations to develop interventions and services that affirm and reflect the value of different cultures. The extent to which interventions and services successfully affirm and reflect these values determines the appropriateness, acceptability, accessibility, and utilization of services (Epstein, 1998).

Diana L. Denboba is a Public Health Analyst for the Division of Services for Children with Special Health Needs, Maternal and Child Health Bureau, Health Resources and Services Administration (HRSA), Rockville, MD 20857. Judith L. Bragdon was formerly a Public Health Analyst in the Division of Nursing, Bureau of Health Professions, HRSA, and currently is a Nurse Consultant with the Health Care Financing Administration (HCFA). Leonard G.Epstein is a Public Health Analyst with the Office of Women's and Minority Health, Bureau of Primary Health Care, HRSA. Karen Garthright is a Public Health Analyst in the Office of Minority Health, HRSA. Thurma McCann Goldman is the Director of the Division of Healthy Start, Maternal and Child Health Bureau, HRSA.

This article will focus on "cultural competence" and how it has been defined and integrated in programs funded by the Health Resources and Services Administration (HRSA) in response to the growing cultural diversity within the United States. The information provided should be helpful to health educators by identifying: (1) potential resources or partners in the delivery of culturally competent health care within HRSA programs, and (2) strategies in operationalizing culturally competent policies and practices through "lessons learned."

Introduction

Definitions

"Culture" is an integrated pattern of human behavior including thought, communication, ways of interacting, roles and relationships, and expected behavior, beliefs, values, practices, and customs (Taylor, 1997). As such, culture influences: (1) how health, illness and disability are perceived; (2) attitudes toward health care providers, facilities, and how health information is communicated; (3) help seeking behaviors; (4) preferences for traditional versus non-traditional approaches to health care; and (5) perceptions regarding the role of family in health care.

The terms "cultural diversity" and "cultural competency" have been used interchangeably when designing strategies to address issues with an increased culturally diverse population. However, conceptually, they are quite different. "Cultural diversity" relates to differences that people present and the knowledge about such differences. These differences can occur in physical characteristics (such as color), with demographic characteristics (such as gender and age), and with socioeconomic characteristics (such as education and occupation) and their historical, sociological, and anthropological bases (Evans, 1997).

"Cultural competence" refers to a individual and program's ability to honor and respect those beliefs, interpersonal styles, attitudes, and behaviors both of families who are clients and the multicultural staff providing services. In doing so, the program is able to incorporate these values at the levels of policy, administration, and practice (Roberts et al., 1990). It takes us from a level beyond cultural sensitivity to a level where "this sensitivity" is integrated into the planning, implementation, and evaluation of service systems and encompasses cultural diversity (Evans, 1997). The following are compelling reasons for ad-

dressing cultural competency in health, as outlined from a Maternal and Child Health Fact Sheet.

Why Cultural Competence Is Important

Although there is a combination of issues (including the impact of poverty) which influence health seeking behavior and utilization of services, culture, ethnicity, and race are major factors in the provision of health care services which are clinically competent and culturally appropriate.

Demographics

Current and projected demographics indicate significantly increased cultural and linguistic diversity within the U.S. population. A report from the 1996 U.S. Census Bureau states: one in every 10 people living in the U.S. were born in another country; the number of persons speaking a language other than English at home rose by 43 percent to 28.3 million since 1980; and, of these, nearly 45 percent report they have difficulty speaking English. The Children's Defense Fund predicts that in the first decade of the year 2000, there will be 5.5 million more Latino/Hispanic children; 2.6 million more African American children; 1.5 million more children of other races while there will be 6.2 fewer white, non-Hispanic children. Health educators must be cognizant of the impact that these demographic changes have relative to the way in which services and educational materials need to be developed and information marketed.

Disparities in Health

Significant disparities remain among large segments of the U.S. population with respect to health care access, utilization, and health outcomes. Population groups identified in the Healthy People 2000 objectives related to child health include members of some racial and ethnic minority populations who are at greater risk for low birth weight, infant mortality, and certain chronic and disabling conditions. For example, in 1995 the infant mortality rate for black infants was still over twice that of whites, while rates for some American Indian tribes and for Puerto Ricans were also higher than that of white infants. Sudden Infant Death Syndrome (SIDS) rates among blacks are 2 1/2 times that of whites and three to four times as high for some Native American/Alaskan Native populations (Koontz, 1997). Deaths in women from cardiovascular disease and cancer are highest among African American and Asian women, respectively. In addition, "physiologic and pharmacokinetic differences and predisposition to certain disorders need to be further explored and understood" (HRSA, 1997).

Historical Discrimination

Among many members of racial/ethnic groups there is still a lack of trust regarding our health care system (particularly with public health) due to "cumulative experience" of historical discrimination; unethical medical practices and experimentation; disparities in the allocation of some diagnostic and therapeutic resources (Gelger, 1997), and a lack of constructive feedback to some racially/ ethnically diverse communities concerning health research. Historically, many culturally/racially diverse groups have had limited access to the political or economic power structures that have influenced the planning and administration of health service systems (Cross et al., 1989). Although culture is broader than race/ethnicity, reactions to racial discrimination in this country continue to be present issues which negatively impact health outcomes, access, and utilization.

Consumer Need

As part of the ongoing Federal, state, and local HRSA needs assessments which utilize bicultural/bilingual focus groups, surveys and interviews, consumers themselves have identified cross-cultural differences as obstacles to care. Families have commented on having to deal with: (1) continued cultural/ethnic bias and stereotypes; (2) offensive communication and interaction based on such biases, and stereotypes and lack of cross-cultural knowledge; and (3) lack of understanding and recognition of the unique values of various cultural groups (Malach, 1996). Accordingly, the most common complaint of consumers from culturally diverse backgrounds is that they have not been treated with dignity (Healthy Start, 1995). In order to have a truly family centered approach to health care, health educators and other providers must identify and then address such barriers to culturally competent care.

Insufficient Cultural/Sensitivity Training in Medical Schools

Although it is acknowledged that the U.S. population is becoming more multicultural, studies have shown that very few medical schools offer "separate, formal cultural-sensitivity courses" and, of those available, most were optional and/or not widely publicized or generally available (Lum et al., 1994; Denboba, 1998).

All the above mentioned factors need to be considered when eliminating health disparities for vulnerable, culturally diverse, populations. One mechanism for addressing such issues is to incorporate culturally competent policies and practices when planning, implementing, and evaluating health care services and systems. The following is a description of how HRSA programs are working toward the goal of cultural competence in health care.

Overview of HRSA Programs

HRSA directs national health programs which seek to assure quality care to underserved, vulnerable, and special need populations by promoting appropriate health professions workforce capacity and practice, particularly in pri-

mary care and public health. The agency includes, but is not limited to, the Office of Minority Health, the Bureau of Primary Health Care, the Maternal and Child Health Bureau, and the Bureau of Health Professions. The following are brief summaries of these selected programs.

The *Office of Minority Health (OMH)* serves as the principle advisor and coordinator to the agency regarding the special needs of minority and disadvantaged populations. The Office establishes objectives, policies, and proposals for health activities and legislation addressing minority and disadvantaged populations, consults with other public and private organizations to assure minority health issues are addressed, and reviews agency wide data and agreements related to these target populations.

The largest bureau within HRSA, the *Bureau of Primary Health Care (BPHC)*, works to increase access to quality, comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. Over eight million people receive services through safety net grant programs and federally funded primary care centers. Safety net grant programs include a network of approximately 700 community and migrant health centers (C/MHCs), providing access to primary and preventive health care for the 65 percent of those users falling below the poverty line and 41 percent of the U.S. population who are uninsured (including the homeless). Initiatives include those designed to address primary care provider shortages and the "Models That Work" Campaign. This campaign, designed to promote excellence and innovation in the delivery of primary and preventive health, is built upon a partnership between BPHC and more than 25 national foundations, associations, and non-profit organizations.

The Maternal and Child Health Bureau (MCHB) has the responsibility for providing leadership to both public and private sectors in order to build the infrastructure for the delivery of health services to all mothers and children in the nation, particularly low-income, isolated, and culturally diverse populations who otherwise would have limited access to care. MCHB administers and monitors approximately 684 million dollars in Maternal and Child Health Services Block Grants to 59 states and jurisdictions with 85 percent of these funds allocated as block grant funds to states' Title V programs, and 15 percent allocated for competitive discretionary grants (Special Projects of Regional and National Significance—SPRANS). MCHB initiatives include: the reduction of infant mortality—the Healthy Start Program; comprehensive care for pregnant women, preventive and primary care for infants and children, including those in day care; genetic screening, services, and counseling; comprehensive care for children with special health care needs and their families, including rehabilitative care for blind and disabled children who are eligible for Supplemental Security Income; and, maternal and child health research and training programs.

Through provision of funding, technical assistance, and consultation, *The Bureau of Health Professions (BHPr)* seeks to promote development of an appropriately trained health professions workforce which will provide primary care services, particularly to unserved and underserved populations. Partners in this endeavor include representatives from the health care industry, health professions education and service entities, such as colleges and universities, community based organizations, as well as state and local governments, private business entities, and foundations. BHPr programs, as well as other HRSA divisions, emphasize the need for increasing cultural diversity in the health professions and equipping health care providers with the education and experience to meet the needs of vulnerable populations in a clinically competent and culturally appropriate fashion. The BHPr supports students through a variety of activities from high school, college, and through completion of health professions degrees, with some post graduate support available.

HRSA's Programs in Cultural Competence

In order to achieve more culturally competent systems which reduce health disparities, all components of the HRSA's service systems are being re-examined, including mission statements, organizational policies and procedures, administrative practices, staffing patterns, staff training, health education and promotion practices, and materials and assessment protocols (Taylor, 1996). The following are summaries of HRSA activities in cultural competency that provide educational opportunities for health providers, communities, and consumers.

OMH has two major initiatives underway. The Minority Management Development Program (MNMP) is a model public/private partnership initiative funded by HRSA, the Health Care Financing Administration (HCFA), the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Minority Health/Office of Public Health and Science (OMH/OPHS), the American Association of Health Plans (AAHP), and its member health plans. The project is a 10-month fellowship program designed to enhance the representation of minority managers and administrators in the managed care industry. The program provides managerial training, work experience, and knowledge of the industry through focused didactic and interactive training opportunities. In addition, Fellows receive a taxable stipend of $27,000 and single health insurance coverage. Upon successful completion of the program, Fellows are provided with placement assistance within the health care industry. The program, begun in the Washington, DC/Baltimore, Maryland area, utilizes area health plans, industry experts, and university faculties. In FY 98 the program is being expanded to the Southwest. In addition to a rotation in HCFA that is currently available to Fellows, a rotation within HRSA will be offered in FY 98.

The other OMH program is with the

National Association of Hispanic-Serving Health Professions Schools. This partnership was founded in 1996 with the support of HRSA and OMH/OPHS to provide national leadership focusing efforts on effectively expanding the pool of Hispanics in the health professions through creation of an educational pipeline of linkages with institutions at the local, State, and Federal levels. Research on Hispanic health issues, cultural competency, and faculty and curriculum development were also identified as necessary tools for health professionals to be appropriately trained to address the health care needs of the rapidly-growing Hispanic population. This partnership between the Federal government, health professions institutions, academic health centers, and the private sector is critical to ensuring the availability of sufficient Hispanics in the health care workforce to meet the needs of the Hispanic population and the Nation in the 21st century. OMH manages a grant to the association and continues to play a key role in providing technical assistance to this new organization. OMH will also be providing the leadership for a new HRSA wide cultural competency work group in collaboration with HRSA's Bureaus and the Center for Managed Care.

BPHC recognizes that provision of linguistically and culturally appropriate services for ethnic, racial, and cultural populations poses a significant challenge for our diverse citizenry. For example, a number of BPHC programs address the needs of specific culturally diverse populations. A successful program begun in Michigan and replicated in seven other states seeks to improve primary health care for migrant farm working women and their families (a particularly hard to reach minority population) by training them as peer "primary care" counselors. BPHC's plans, policies, and procedures in headquarters—through its field offices in Boston, Denver, Seattle, New York, and Philadelphia—and in clinics reflect principles of culturally competent care for its customers. Although this is true throughout BPHC's programs, its Office of Minority and Women's Health (OMWH) was designed specifically for that purpose. This office has a number of initiatives in cultural competency involving program evaluation, issues of multicultural staff, and staff orientation. OMWH has contracts to determine how Community/ Migrant Health Centers (C/MHCs) serving high populations of clients having English as a second language are accommodating these clients and to look at sub-population data—identifying which subgroups within racial/ethnic groups are being served and their locations, and identifying the location and expertise of providers with similar cultural backgrounds. There is an effort underway to look at issues of multicultural National Health Service Corps providers working in C/MHCs and the impact of multicultural staff on client experiences. In addition, the BPHC provides orientation and training for its federal, regional, and program staff in issues related to cultural competency. This training effort as well as additional program assessments will be further expanded by a collaborative agreement with MCHB and its center for cultural competency. In addition, a series of monographs are in the process of being developed with the Department of Health and Human Services' Office of Minority Health and the Center for Substance Abuse Prevention in the Substance Abuse and Mental Health Services Administration (SAMHSA).

MCHB has had a commitment to improve services to culturally diverse populations. For over a decade, with leadership from the Division of Services for Children with Special Health Care Needs (DSCSHCN), MCHB has been promoting the integration of cultural competency into its: (1) state and local program systems building efforts; (2) state block grant requirements and performance measures; (3) discretionary grant requirements and programs; (4) consumer/family advocacy, and support networks; (5) Federal advisory and ad hoc committees; and (6) networking and collaborative activities with other public and private organizations. Initiatives have included funding Genetic/Hemophilia discretionary grants designed to enhance the utilization of genetic services by Southeast Asian refugees, and, projects to help overcome ethnocultural barriers and increase utilization of genetic and hemophilia treatment services for populations, such as Latino immigrants, confronted by language and cultural barriers.

As a result of a "cultural competency mentoring relationship" with the Child and Adolescent Service System Program's Minority Initiative Resource Committee funded by SAMHSA, the DSCSHCN met with State CSHCN program directors, families, and consultants to work on issues and solutions specific to culturally diverse populations. Such activities culminated in the funding of two successive MCH National Centers for cultural competence, the first with the Texas Department of Health and the most current with the Georgetown University Child Development Center. The current center provides technical assistance, train the trainer opportunities, develops assessment tools, and coordinates and implements agency self-assessments for state and local CSHCN programs.

Other discretionary initiatives include activities in partnership with Navaho and other Native American and Alaskan Native populations for integrating early intervention and health services, assisting with the implementation of cultural competency in managed care programs, and development of family-centered, culturally competent primary care medical homes for children with special health care needs and their families.

In addition, many State CSHCN (Title V) programs have found innovative ways of incorporating cultural competency. Some, such as Washington, New Mexico, New York, and Ohio have their own ongoing work or study groups on cultural competency. Other programs such as Washington, Wisconsin, and Alaska have participated in agency self-assessment procedures in order to better plan services. California is working with the state legislature in requiring culturally

competent services. Texas and Oregon have revised policies and implemented new administrative entities to work closely with diverse populations and communities.

A unique aspect of the Healthy Start Initiative is implementation of cultural competency as an essential component of working with community development activities designed to integrate perinatal services. Through this approach, communities are working toward reducing health disparities of racial/ethnic populations in the area of infant mortality. Program strategies include training health professionals and indigenous multi-cultural community outreach workers how to operationalize family centered, culturally competent principles into practice, such as with the Oakland Healthy Start Program's "Males as Agents of Family Empowerment and Community Revitalization" training. The Baltimore Healthy Start Program utilizes male African American role models within the community and support groups to assist young men in manhood and fatherhood development. Public service announcements involving multimedia campaigns incorporate bi-lingual and multi-cultural characters and messages for a more effective approach toward public awareness and education. Model strategies and lessons learned from working with a broad range of diverse communities and families have been published by Healthy Start in a five volume series, the *Healthy Start Initiative, A Community-Driven Approach to Infant Mortality Reduction.*

DSCSHCN supports/funds its partners—consumer advocacy groups and Parent Training and Information Centers (the Department of Special Education)—in working together on issues of cultural competence in systems of care including local and state health departments, clinics, and managed care plans. Consumer advocacy groups in states such as Michigan, and groups like "Family Voices" and the "National Fathers' Network," have made concerted efforts to reach out to minority families to provide health education, leadership skill development, and emotional support. Parents Helping Parents (CA), has been working with states and Kaiser Permanente in institutionalizing parent directed bi-lingual, bicultural family resource centers in health facilities. In addition, a new national advocacy group consisting of culturally diverse consumers and professionals across disciplines was formed. This "National Family for the Advancement of Minorities with Disabilities" serves to provide a network of support and opportunities for those of diverse cultures who have disabilities or those who serve individuals with disabilities.

MCHB also has training/continuing education programs that focus on culturally diverse populations. The University of Minnesota, for example, has been bringing together providers, administrators, and families in discussions of papers addressing issues specific to racial/ethnic groups. Research, such as "Poverty and the Ecology of African American Children" also is being funded and is specific to the development of measures of racism and its consequences for the health of mothers and children.

The *BHPr* supports numerous health professions education programs which focus on increasing cultural representation within the health care work force, with approximately 30 percent of its budget for programs dedicated specifically to improving the cultural representation of the health workforce and approximately 70 percent of the budget supporting numerous health professions education programs, with a priority in funding those education/training entities graduating more diverse practitioners or those more likely to work in underserved areas. While under represented minorities comprise about 10 percent of the nation's health workforce, BHPr sponsored programs in physician assistant training, general practice dentistry and preventive medicine residencies, and public health traineeships produce graduates who respectively are 32 percent, 33 percent, 19 percent and 26 percent.

BHPr's Division of Disadvantaged Assistance has a long history of serving as a leader in the development and support of grant programs with a focus on the recruitment, retention, and graduation of disadvantaged and minority students in the health professions through such grants efforts such as the Health Careers Opportunity Program and Centers of Excellence Psrogram. Within these programs cultural competency is being addressed in training curricula, health research, and student experiences in culturally diverse community clinics.

The Division of Nursing (DN) has likewise been chiefly responsible for development and support of basic and advanced professional nursing programs which have trained nurse practitioners, nurse anesthetists, nurse midwives, and clinical nurse specialists. "The Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds" (NEO) program has specifically supported identification, preliminary education, recruitment, retention, and faculty research for minority individuals and those from academically and/or economically disadvantaged settings. The Division has served in a leadership role in continuing development of a consensus regarding definition of "cultural competency," and in the identification of workforce distribution patterns through its sponsorship of three national Minority Congresses and a national sample survey of nurses.

Lessons Learned

The following are lessons learned by HRSA's DSCSHCN, Healthy Start, and BPHC staff and programs through marketing and implementation of cultural competency programs.

Individual Growth and Understanding

* The process of striving for cultural competency is an *ongoing journey*, beginning with understanding one's own culture and how it has formed one's perception of self, of others, and of what is good or bad (Evans, 1997).

* Establishing and renewing personal

relationships with individuals of different cultures inside and outside the work environment helps to broaden perspectives.

* Gaining knowledge of other cultures with a goal of understanding, rather than judging, them and resisting stereotyping others is a key element in expanding our worldview and appreciating the health care clients we serve.

Partnerships

* Developing a network of parents, advocates, and community leaders, including those representing culturally diverse populations, is essential to having relevant input on advisory committees, quality evaluation and improvement activities, document reviews, and partners in training.

* Developing partnerships with other local, state, and national organizations involved in cultural competency efforts as well as racial/ethnic specific professional organizations—a "mentor or partner agency"—can provide additional support, resources, and a broader knowledge base which promotes sensitivity and appropriate delivery of care.

Systems/Program Capacity Building

* Support from high level administration is critical to promotion of administrative, staffing, and policy changes as well as redefining priorities.

* Training at all levels of staff by skilled and non-judgmental trainers, through a variety of ongoing activities, increases knowledge, understanding, and cross-cultural skills. However, it is essential to guard against training and activities which reinforce stereotypes.

* Development of an organization/agency wide work group or task force that includes community input is instrumental in providing a mechanism for staff from a variety of programs to come together resulting in a broad base of support, information sharing, and shared responsibility.

* Having a vision of cultural competency principles incorporated into everyday work of the program rather than a "separate initiative enabled staff to appreciate the far reaching, ongoing importance of this effort" (Evans, 1997).

* Resource development is crucial: a central, easily accessed location of all state resources, including possible local, state, and national lists of consultants, medical interpreters and videos, as well as examples of guidelines, contract language, and model program descriptions, can be helpful.

* An organization may consider conducting an informal or formal cultural competency assessment, which includes a consumer component, to identify areas of strength, areas which can be enhanced, and which provides a basis for planning priorities and activities.

Program Practice

* Help to make the site more comfortable and appealing to diverse ethnic groups through magazines, posters, and other art work representative of the populations served.

* Learn more about the community and populations served. Break the cycle of "program isolation" from the broader community.

* Break down communication barriers, including language barriers. Interpreters and translators must be culturally appropriate and sufficiently trained (effective medical interpretation).

* Design media campaigns with the community to ensure positive messages/images which are culturally appropriate.

* It should be recognized that everyone benefits from such training, increased sensitivity-providers feel more comfortable, and the skills developed help make programs more understanding of *all families.*

In summary HRSA's role in the area of cultural competence has been and will continue to be providing leadership, guidance, and opportunities for collaboration in training, developing community and consumer partnerships, developing model strategies, and research. HRSA invites health educators to become partners with its programs in the area of cultural competency.

For resources in cultural competency that have been developed by HRSA programs, see the article in this publication entitled, *Reducing Health Disparities: Ideas for Resources Development and Technical Assistance* by Johnston et al. For additional information on HRSA national, state, and local efforts, contact: Karen Garthright, OMH, (301) 443-9424; Diana Denboba, MCH, (301) 443-2370; Len Epstein, BPHC, (301) 594-3803; or Ciriaco Gonzales, BHPr, (301) 443-2100.

We appreciate the informational contributions and comments from Sharon Barrett and Ciriaco Gonzales.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M. (1989). *Toward a culturally competent system of care—volume I.* Georgetown Child Development Center: Washington, DC.

Denboba, D. (1998). *Fact sheet: Cultural competence.* Division of Services for Children with Special Health Care Needs/Integrated Services Branch.

Epstein, L. (1998). Unpublished draft. HCFA.

Evans, J. (1997). *Journey towards cultural competency: Lessons learned.* National MCH Resource Center on Cultural Competency. Texas Department of Health: Austin, TX.

Evans, J. (1997). *Pursuing organizational and individual cultural competency.* National MCH Resource Center on Cultural Competency. Texas Department of Health: Austin, TX.

Gelger, J.H. (Nov. 1997). Annotation: Racism resurgence—building a bridge to the 19th century. *American Journal of Public Health, 87*(11).

Healthy children 2000: National health promotion and disease prevention objectives related to mothers, infants, children, adolescents, and youth. DHHS. Publication No. HRSA-M-CH 91-2.

Healthy people 2000 review. (1992). DHHS Publication No. (PHS) 93-1232-1.

The healthy start initiative, a community-driven approach to infant mortality reduction. (1994). Volume I-Consortia Development; Volume 11-Early Implementation: Lessons Learned;

Volume IV-Community Outreach.

HRSA. (Fall, 1997). Health care for women of color/developing cultural competence. *Journal for Minority Medical Students—The Black Bag.* Spectrum Unlimited: Washington, DC.

Koonz, A. (1997). Unpublished draft. HRSA.

Lum, C.K. et al. (1994). Cultural sensitivity training in medical schools. *Academic Medicine, 69.*

Malach, R., Nelkin, V.S., & Jones, D.A. (1996). *Family perspectives: Cultural/ethnic issues affecting CSHCN—educational fact packets.* Southwest Communications Resources: Bernalillo, NM.

Mason, J. *The cultural competency self-assessment for CSHCN agencies.* Maternal and Child Health National Center for Cultural Competence. Georgetown University Child Development Center: Washington, DC.

Roberts, R., Barclay-McLaughlin, G., Cleveland, J., Colston, W., & Malach, R. (1990). *Developing culturally competent programs for families of children with special needs,* 2nd Ed. Georgetown University Child Development Center: Washington, DC.

Randall-David, E. (1989). *Strategies for working with culturally diverse communities.* Association for the Care of Children's Health: Washington, DC.

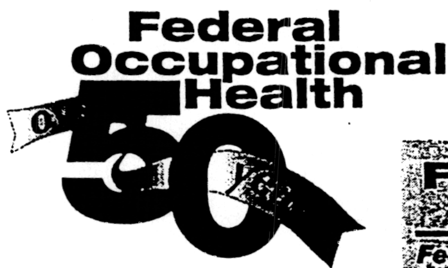
Taylor, T. (1996). Cultural competence: Implications for service delivery to children with special health needs and their families. *Curriculum: An interdisciplinary approach: Nutrition makes a difference.* Children's Hospital, USC-UAP: Los Angeles, CA.

Government Downsizing

Creates headaches with
fewer employees,
smaller budgets,
time-consuming contracting

Federal Occupational Health

Cures headaches with
more productive employees,
cost-effective programs,
easy interagency agreements



Federal Occupational Health designs clinical, employee assistance and environmental health programs to fit your needs. Keep your agency working, call today.

Federal Managers call 800-457-9808
www.foh.dhhs.gov

Federal Occupational Health is part of the US Public Health Service and the Health Resources & Services Administration